Methodist Physicians' Alliance for Quality

Transitional Care Management Services

Updates on the New Codes and How to Implement in your Practice

Background

Effective January 1, 2013, Medicare pays for two new Transitional Care Management (TCM) codes to improve care coordination and to provide better incentives to ensure patients are seen in a physician's office, rather than be at risk for readmission.

Transitional care management is comprised of one face-to-face visit within the specified timeframes, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professionals and/or licensed staff under his/her direction.

The two codes are based on patient complexity with more complex patients requiring a face-to-face visit sooner after hospital discharge.

- 99495 TCM Code (Moderate Complexity)
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 *business* days post-hospital discharge
  - Medical decision making of at least moderate complexity during the service period
  - Face-to-face visit, within 14 *calendar* days post-hospital discharge
- 99496 TCM Code (High Complexity)
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 *business* days post-hospital discharge
  - Medical decision making of high complexity during the service period
  - Face-to-face visit, within 7 *calendar* days post-hospital discharge

What does this mean for you?

Contacting your patients shortly after hospital discharge and following up with a face-to-face office visit enhances patient satisfaction, improves care coordination, and potentially rewards you for preventing a hospital readmission within 30 days of discharge.

How to implement in your office?

- Educate your patients about the need to inform you if they are admitted to the hospital. Ask them to call your office when they are admitted and when they are discharged.

- Call patients within 2 business days of hospital discharge to discuss any questions or needs they may have. If they have any clinical issues, ask a clinical provider in your office (e.g., Nurse, Physician, etc.) to follow up with the patient as soon as possible.

- Ask your clinical provider if the patient should come in for a face-to-face visit within 7 days (high complexity) or 14 days (moderate complexity) of hospital discharge. In general, the patients with more complex medical issues will need to be seen sooner.

- Be sure your clinical provider has all of the necessary information about the patient's hospital discharge to review prior to the face-to-face visit. If you are unable to obtain what you need from the patient, contact the Care Navigators at Houston Methodist for assistance. The care navigator staff will fax or email information to you within 1 business day of the request.

- Inform your billing/claims department of the TCM service. Claims should be submitted only once during the 30-day TCM service period (i.e, Day 1 is the day of hospital discharge). The reported date of service should be the 30th day. The location of service should correspond to your clinic location.

Frequently Asked Questions about Billing Medicare for Transitional Care Management Services

Effective January 1, 2013, Medicare pays for two CPT codes (99495 and 99496) that are used to report physician or qualifying nonphysician practitioner care management services for a patient following a discharge from a hospital, SNF, or CMHC stay, outpatient observation, or partial hospitalization. This policy is discussed in the CY 2013 Physician Fee Schedule final rule published on November 16, 2012 (77 FR 68978 through 68994). The following are some frequently asked questions that we have received about billing Medicare for transitional care management services.

- **What should practitioners do if claims for appropriately furnished Transitional Care Management (TCM) have been rejected or denied by Medicare?**

  We understand that many practitioners have had difficulty being paid for TCM services, which are new services beginning January 1, 2013. In many cases, claims submitted for TCM services have not been paid due to several common errors in claim submission. We encourage practitioners to verify that all requirements for furnishing the service have been met, and if so, to re-submit any unpaid claims. In particular, the practitioner should ensure that the entire 30-day TCM service was furnished on or after January 1, 2013 (i.e. discharge occurred on or after January 1, 2013), that the service began with a qualified discharge from a facility, and that the date of service on the claim is the final day of the period of TCM services (the 30-day period for the TCM service begins on the day of qualified Medicare discharge and continues for the next 29 calendar days. The reported date of service should be the 30th day). We also have made some adjustments to our claims processing systems to better accommodate the unique billing requirements of this new, 30-day service. We believe that with the adjustments that we have made and extra care with billing on behalf of practitioners, that the problems that have been encountered will be alleviated.

- **What date of service should be used on the claim?**

  The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days. The reported date of service should be the 30th day.

- **What place of service should be used on the claim?**

  The place of service reported on the claim should correspond to the place of service of the required face-to-face visit.

- **If the codes became effective on Jan. 1 and, in general, cannot be billed until 29 days past discharge, will claims submitted before Jan. 29 with the TCM codes be denied?**

  Because the TCM codes describe 30 days of services and because the TCM codes are new codes beginning on January 1, 2013, only 30-day periods beginning on or after

January 1, 2013 are payable. Thus, the first payable date of service for TCM services is January 30, 2013.

- **The CPT book describes services by the physician's staff as "and/or licensed clinical staff under his or her direction." Does this mean only RNs and LPNs or may medical assistants also provide some parts of the TCM services?**

  Medicare encourages practitioners to follow CPT guidance in reporting TCM services. Medicare requires that when a practitioner bills Medicare for services and supplies commonly furnished in physician offices, the practitioner must meet the "incident to" requirements described in Chapter 15 Section 60 of the Benefit Policy Manual 100-02.

- **Can the services be provided in an FQHC or RHC?**

  While FQHCs and RHCs are not paid separately by Medicare under the PFS, the face-to-face visit component of TCM services could qualify as a billable visit in an FQHC or RHC. Additionally, physicians or other qualified providers who have a separate fee-for-service practice when not working at the RHC or FQHC may bill the CPT TCM codes, subject to the other existing requirements for billing under the MPFS.

- **If the patient is readmitted in the 30-day period, can TCM still be reported?**

  Yes, TCM services can still be reported as long as the services described by the code are furnished by the practitioner during the 30-day period, including the time following the second discharge. Alternatively, the practitioner can bill for TCM services following the second discharge for a full 30-day period as long as no other provider bills the service for the first discharge. CPT guidance for TCM services states that only one individual may report TCM services and only once per patient within 30 days of discharge. Another TCM may not be reported by the same individual or group for any subsequent discharge(s) within 30 days.

- **Can TCM services be reported if the beneficiary dies prior to the 30th day following discharge?**

  Because the TCM codes describe 30 days of care, in cases when the beneficiary dies prior to the 30th day, practitioners should not report TCM services but may report any face-to-face visits that occurred under the appropriate evaluation and management (E/M) code.

- **Medicare will only pay one physician or qualified practitioner for TCM services per beneficiary per 30 day period following a discharge. If more than one practitioner reports TCM services for a beneficiary, how will Medicare determine which practitioner to pay?**

  Medicare will only pay the first eligible claim submitted during the 30 day period that commences with the day of discharge. Other practitioners may continue to report other

reasonable and necessary services, including other E/M services, to beneficiaries during those 30 days.

- **Can TCM services be reported under the primary care exception? Can the services be reported with the –GC modifier?**

  TCM services are not on the primary care exception list, so the general teaching physician policy applies as it would for E/M services not on the list. When a physician (or other appropriate billing provider) places the -GC modifier on the claim, he/she is certifying that the teaching physician has complied with the requirements in the Medicare Claims Processing Manual, Chapter 12, sections 100.1 through 100.1.6.

- **Can practitioners under contract to the physician billing for the TCM service furnish the non-face to face component of the TCM?**

  Physician offices should follow "incident to" requirements for Medicare billing. "Incident to" recognizes numerous employment arrangements, including contractual arrangements, when there is direct physician supervision of auxiliary personnel.

  This issue is addressed in greater detail in the Internet-only Benefit Policy Manual, Chapter 15, Section 60 available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html

- **During the 30 day period of TCM, can other medically necessary billable services be reported?**

  Yes, other reasonable and necessary Medicare services may be reported during the 30 day period, with the exception of those services that cannot be reported according to CPT guidance and Medicare HCPCS codes G0181 and G0182.

- **If a patient is discharged on Monday at 4:30, does Monday count as the first business day and then Tuesday as the second business day, meaning that the communication must occur by close of business on Tuesday? Or, would the provider have until the end of the day on Wednesday?**

  In the scenario described, the practitioner must communicate with the patient by the end of the day on Wednesday, the second business day following the day of discharge.

- **Can TCM services be reported when furnished in the outpatient setting?**

  Yes. CMS has established both a facility and non-facility payment for this service. Practitioners should report TCM services with the place of service appropriate for the face-to-face visit.

Methodist Physicians' Alliance for Quality

Transitional Care Management Codes

(This TCM general information is not to be used as a training tool)

TCM is a 2- part process for inpatient discharges with a goal to decrease re-admissions.

Part 1 - the office staff assigned will:

- Receive a list of patients discharged daily from Houston Methodist Inpatient Stay
- Contact patient or caregiver within two business days of discharge and document in Telephone documentation smart phrase (if unable to reach must document attempts)
- Smart Phrase for Telephone documentation will prompt:
  - Evaluate the patient status, medications, treatments, and resources ordered/obtained, caregiver status, and obtain any additional orders needed
- Make follow up appointment for provider within 7 or 14 days of the discharge by use of TCM visit type

The office visit process:

- Patient presents at follow up TCM appointment and is checked in
- Screening nurse will follow TCM Smart Phrase Tip Sheet
- Provider will review data in note from screening nurse and follow Provider TCM Smart Phrase tip sheet

Code	Description
99495	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge

Code	Description
99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge

Recommendation for use:

- Office Clinical Staff and Providers will receive comprehensive education on TCM documentation requirements prior to using.
- TCM Codes will be reviewed at 100% for compliance of required elements
- TCM codes are held for 30 days post discharge date for billing compliance.

**Courtesy of Deaconess Clinic*

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Transitional Care Management 30-Day Worksheet

Patient name: _____ DOB: _____

D/C physician: _____ D/C date: _____

Records requested: Records received: Reviewed:

Diagnoses on discharge:	
Date of interactive contact (2 business days post D/C):	☐ Phone ☐ Email ☐ Direct ☐ Other
Date of 7-day or 14-day, face-to-face visit:	
Family and/or caretaker present at visit:	

Medications on discharge	Medication changes/adjustments

Diagnostic tests reviewed/disposition:
Disease/illness education:
Home health/community services discussion/referrals:
Establishment or re-establishment of referral orders for community resources:
Discussion with other health care providers:
Assessment and support of treatment regimen adherence:
Appointments coordinated with:
Education for self-management, independent living, and activities of daily living:

TCM.January 2013

SUBMIT BILLING 30 DAYS POST DISCHARGE.

Physician completes colored areas
Staff completes remainder

Medical Decision Making			
DIAGNOSIS and MANAGEMENT	**QTY**	**POINTS**	**TOTAL**
Self-limited or minor — stable, improv, or prog as expected		1	=
Established prob — stable, improving		1	=
Established prob — worsening		2	=
New prob — no further workup planned		3	=
New prob — additional workup planned		4	=
DIAGNOSIS and MANAGEMENT TOTALS			=

DATA REVIEWED	
Review/order of clinical lab tests (80000 code series)	1
Review/order of radiology tests (70000 code series)	1
Review/order of medicine tests (90000 code series)	1
Discuss test w/performing or interpreting physician	1
Decision to obtain old records or history from someone other than patient	1
Review and summary of old records and/or ***obtaining*** history from someone other than pt and/or discussion w/another provider **with documentation of findings**	2
Independent visualization of actual image, tracing, or specimen **(not simply review of report)**	2
DATA REVIEWED TOTAL	

TABLE OF RISK		
Moderate	Presenting Problem	1+ chronic ill w/milk exac, prog, or tx side effects, 2+ stable chronic ill, Undx new prob with uncertain prog (lump in breast), Acute ill w/systemic symp (pyeloephritis, Pneumonitis, colitis), Acute comp injury (head inj w/brief loss of consciousness)
	Diag Procedure Ordered	Physiologic tests under stress, Diag endos w/no identified risk, Deep needle or inc bx, Cardio imag w/cont, no identified risk, Obtain fluid from body cavity (lumbar puncture, thoracentesis)
	Mgmt Options	Minor sx w identified risk, Elec major sx (open, perc, endos) w/no identified risk, Rx drug mgmt, Therapeutic nuclear medicine, IV fluids w/additives, Closed treatment of fx or dislocation w/o manipulation
High	Presenting Problem	1+ chr ill w/severe exac, prog, tx side effects; Acute/chr ill or inj posing threat to life/bodily func (trauma, MI, pulm emb, sev resp dist, prog sev rheum arth, psych ill w/pot threat to self or others, renal fail); Sz, TIA, weakness, sens loss
	Diag Procedure Ordered	Cardio img w/cont and risk; Cardio electrophysiological tests; Diag endoscopies w/identified risk factors; Discography
	Mgmt Options	Elective major sx (open, perc, endo w/risk); Emerg major sx; Parenteral cont subs; Rx therapy w/intensive monitoring for toxicity; Decision not to resuscitate or to de-escalate care because of poor prognosis

(2 of 3 elements must be met or exceeded for a level of decision making)

MDM:	SF	Low	Mod	High
DX MGMT Options	0-1	2	3	4+
Data	0-1	2	3	4+
Risk	Minimal	Low	Moderate	High

NOTES:

Physician signature: _____

Staff signature: _____

Staff signature: _____

Staff signature: _____

TCM.January 2013
Courtesy of AAFP

SUBMIT BILLING 30 DAYS POST DISCHARGE.

Physician completes colored areas
Staff completes remainder

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Frequently Asked Questions: Transitional Care Management

Q1: What is transitional care management (TCM)?

A1: TCM includes services provided to a patient whose medical and/or psychosocial problems require moderate or high-complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domicile, rest home, or assisted living).

Q2: What current procedural terminology (CPT) codes do I use to report TCM?

A2: There are two CPT codes that may be used to report TCM, effective January 1, 2013:

- 99495 Transitional Care Management Services with the following required elements:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision making of at least moderate complexity during the service period
  - Face-to-face visit within 14 calendar days of discharge
- 99496 Transitional Care Management Services with the following required elements:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision making of high complexity during the service period
  - Face-to-face visit within 7 calendar days of discharge

Q3: How much are these new services worth?

A3: Payment allowances will vary by payer, and Medicare's allowance will vary geographically. Also, Medicare's allowance will depend on the conversion factor in force at the time claims are paid.

Based on these RVUs and the current (2012) conversion factor, the Medicare allowance for code 99495 performed in a non-facility setting (e.g., a physician's office) would be approximately $164; in a facility setting, the corresponding allowance would be approximately $135. For code 99496 performed in a non-facility setting, the Medicare payment allowance would be approximately $231.12; when performed in a facility setting, it would be approximately $197.76.

Q4: Is TCM reportable for new and established patients?

A4: Effectivie February 2013, TCM codes can be utilized on New or established patients.

Q5: I understand that TCM also includes a lot of non-face-to-face care provided by the physician and his or her clinical staff. What are some examples?

A5: Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, may include:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Communication with home health agencies and other community services utilized by the patient
- Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living
- Assessment and support for treatment regimen adherence and medication management
- Identification of available community and health resources
- Facilitating access to care and services needed by the patient and/or family

Non-face-to-face services provided by the physician or other qualified health care provider may include:

- Obtaining and reviewing the discharge information (e.g., discharge summary, as available, or continuity of care documents)
- Reviewing need for, or follow-up on, pending diagnostic tests and treatments
- Interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems
- Education of patient, family, guardian, and/or caregiver
- Establishment or reestablishment of referrals and arrangement of needed community resources
- Assistance in scheduling any required follow-up with community providers and services

Q6: Why shouldn't I just bill an office visit (e.g., CPT code 99214) instead?

A6: The total RVUs for a 99214 in 2013 will be 3.13, which translates to $106.54 using the current (2012) conversion factor. Thus, even 99495 in the office setting will pay almost $60 more than billing an office visit; this additional amount will help compensate the practice for the non-face-to-face physician time and significant clinical staff time that TCM services require over and above the included face-to-face visit.

Q7: If the patient needs another visit during the 30 days, can I bill for this?

A7: Yes, for an E/M visit you can bill additional visits other than the one bundled E/M visit in the TCM. There are some restriction on what you can bill such as anticoagulation management, home health care certification and other miscellaneous forms.

We've yet to hear how these are getting paid since the earliest bill day would have been January 30, 2013. We are also waiting on CMS to release guidelines on the codes. CMS is expected to release that for us by end of February.

continued on the next page

Transitional Care Management FAQs, continued

AAFP has posted a form created to help you document the requirements of TCM visits as well as frequently asked questions that are available for your download. TCM was also discussed as part of the Webinar, "What's new in Medicare and Medicaid payment in 2013" hosted on Delta Exchange.

Q8: May I report a discharge management code and a TCM code?

A8: A physician or NPP may report both the discharge code and appropriate TCM code if he or she provided both services. However, Medicare will prohibit billing a discharge day management service on the same day that a required E/M visit is furnished under the CPT TCM codes for the same patient. That is, you cannot count an E/M service as both a discharge day service and the first E/M under the TCM codes.

Q9: Does the discharge visit count as the post discharge contact?

A9: No, the discharge visit does not count. The initial contact must be made after the patient leaves the hospital. It is to make sure that the patient has the support necessary until they have their face-to-face visit within the 7 or 14 days as prescribed. The initial contact can be phone, e-mail, and text or direct face-to-face. It can be with the patient or their caregiver.

Q10: How is a "business day" defined, and what happens if I can't reach the patient and/or caregiver in that timeframe?

A10: For the purposes of TCM, business days are Monday through Friday, except holidays, without respect to normal practice hours or date of notification of discharge. If two or more separate attempts are made in a timely manner, but are unsuccessful and other TCM criteria are met, the service may be reported. Medicare, however, expects attempts to communicate to continue until they are successful.

Q11: May more than one physician report TCM services for the same patient during the 30 days post-discharge?

A11: No. TCM services may be billed by only one individual during the 30-day period after discharge. If more than one physician or NPP submits a claim for TCM services provided to a patient in a given 30-day period following discharge, Medicare will pay the first claim that it receives that otherwise meets its coverage requirements.

Q12: If I provide a 10- or 90-day global surgical service that results in TCM post-discharge, may I report both the global surgical service and a TCM code?

A12: No. Both CPT and Medicare prohibit a physician who reports a service with a global period of 10 or 90 days from also reporting the TCM service. CPT and Medicare preclude a physician from reporting certain other services with TCM; please consult CPT 2013 for a complete list of these services.

Q13: Who can complete the medication reconciliation for TCM?

A13: TCM medication reconciliation requires that the medications on discharge be reconciled with the medications that the patient was taking previously. The nurse can obtain these medications but the physician needs to order any changes, additions or deletions to the medication.

Q14: Must the required face-to-face visit be in the office?

A14: No. While the visit will typically be in the office, it may also be in the patient's home or another location where the patient resides.

Q15: What happens if the patient is re-admitted before the 30 days are up?

A15: The face-to-face visit would become the appropriate level evaluation and management code for the service that was rendered. You would start your 30 days of service on the TCM over once the patient was discharged.

Q16: Do you have to be a primary care physician to bill TCM services?

A16: No. Neither CPT nor Medicare restricts use of the TCM codes to specific specialties. Likewise, qualified NPPs may also bill these services.

Q17: What time period does a TCM code cover?

A17: TCM commences on the day of discharge and continues for the next 29 days.

Q18: What diagnosis code(s) do I use when reporting TCM?

A18: Report the diagnosis(es) for the conditions that require TCM services. Typically, these will be the conditions that the patient had at the time of discharge, which represents the start of TCM.

Q19: When do I bill for Transitional Care Management?

A19: You should submit your bill on the 30th day after discharge. TCM covers 30 days of management services with one evaluation service bundled in to the code. The date of service on the claim would be the 30th day post the discharge.

Q20: Will these services be subject to co-insurance and deductible under Medicare?

A20: Yes.

Q21: What are the coding limitations associated with TCM?

A21:

- A physician or other qualified health care professional who reports codes 99495, 99496 may not report care plan oversight services (99339, 99340, 99374-99380),
- prolonged services without direct patient contact (99358, 99359),
- anticoagulant management (99363, 99364),
- medical team conferences (99366-99368)
- education and training (98960-98962, 99071, 99078)
- telephone services (98966-98968, 99441-99443)
- end stage renal disease services (90951-90970)
- online medical evaluation services (98969, 99444)
- preparation of special reports (99080)
- analysis of data (99090, 99091)
- complex chronic care coordination services (99481X-99483X),
- medication therapy management services (99605-99607) during the time period covered by the transitional care management services codes.

Transitional Care Management (TCM) ALGORITHM

STEP #1 Patient Discharged from Hospital with High or Low Medical Decision Making (MDM)

YES

See Step #2

NO

TCM code cannot be billed

Bill E& M at normal office visit follow up

STEP #2

Has intial patient contact been made within 2 business days post discharge?

YES

1) Set up face-to-face follow up visit

2) Document in pt chart

NO

1) If unreachable, document in pt chart

2) retry until patient is contacted

YES

Moderate - follow up visit scheduled no longer than 14 calendar days after discharge date

High - follow up call scheduled no longer than 7 calendar days after discharge date

NO

If pt is not reached and follow up visit is not scheduled, TCM code cannot be billed

Bill E& M at normal office visit follow up

STEP #3

Have you furnished certain services to the patient prior to face-to-face appointment if necessary?

Example: discharge summary or continuity of care documents, establish/re-establish referrals

YES

Enter pt date in pt chart

NO

If no data necessary, document in pt chart

STEP #4 Day of face-to-face follow up visit

Do not bill for this visit -- Billing occurs on 29th calendar day after discharge

YES

The Following Must Be Met:

Medication reconcilliation management performed an documented?

YES

Obtained, reviewed and documented discharge information?

YES

MDM of Moderate or High Complexity?

High MDM

Document in EHR and See Step #3

Moderate MDM

Document in EHR and See Step #3

STEP #5 Mark on Fee Ticket

High MDM

Saw Patient within 7 calendar days after discharge:

Mark Transitional Care, Date of Hospital Discharge & 99496 on fee ticket

Moderate MDM

Saw Patient within 14 calendar days after discharge:

Mark Transitional Care, Date of Hospital Discharge & 99495 on fee ticket

Billing will automatically occur on 29th day after discharge